

Book of the month

Patients, Power and Responsibility

Despite Government rhetoric about putting patients at the centre of the health service, British people still have limited choice and little control over what happens to them in their encounters with the NHS. John Spiers' basic thesis is that patients cannot be truly empowered unless they are given direct control of the resources to purchase their own healthcare. In *Patients, Power and Responsibility*¹ he outlines a radical proposal for changing the structure and funding of the British healthcare system which he claims will lead to greater equity, fairness, social solidarity and personal responsibility.

In Spiers' reformed NHS the patient would become a fundholder with entitlement to a voucher to purchase essential core services. The Government would relinquish responsibility for purchasing and providing services, its role being reduced to that of regulator and guarantor of access, choice and competition. Taxation-funded compulsory insurance would cover the guaranteed care package with universal protection for catastrophic and costly medical events, but with a voluntary element enabling people to negotiate a specific package of care and provision for 'top-up' insurance.

The basic package—Spiers calls this PGC ('patient-guaranteed care' or 'pretty good care') would be clearly specified and purchased by competing cooperative insurers ('patient-guaranteed care associations') from a diverse range of providers. Patients would be free to choose between these purchasing associations and they would receive financial incentives to adopt healthy lifestyles or to take charge of their own chronic disease management. The healthcare system would operate according to market principles using legally enforceable contracts with providers who would set their own prices and publish information on their quality standards.

The suggestion that an insurance-based system with vouchers for patients is a better way to pay for health services has been heard before in the UK. Indeed a similar idea is currently being floated by Norwich Union Healthcare and the National Economic Research Associates.² The starting assumption is that tax funding will not deliver the sustained increase in resources that will be required to provide good quality healthcare in the future. Proponents argue that a centralized tax-funded system is necessarily less efficient and less responsive than one based on a competitive insurance model.

Spiers admits that many of his ideas are not new, but he makes a cogent—although ultimately unpersuasive—case for considering this option. The style is ideological and polemical, but Spiers has read widely and he demonstrates his erudition with extensive quotation from a diverse range of sources including political and economic theory and literature. He has a particular penchant for the views of American libertarians such as Virginia Postrel, but Charles Dickens, Matthew Arnold, Isaiah Berlin, Noel Coward and many others are also cited to support his case.

Spiers believes that the State should be an enabler rather than a provider of services. Individual consumers should be allowed to spend their health credit as if it was their own money and patients must be trusted to determine their own best interests. He objects strongly to the notion that resources should be distributed according to professionally defined 'needs' or that government should attempt to manage demand and ration services. His special *bêtes noires* are the 'stasists' who think they know our interests better than we do ourselves. In this camp he includes Sidney and Beatrice Webb, originators of the Fabian tradition that had such a strong influence on the development of the British welfare state, the centralizing, managerialist tendency of recent governments, the public sector unions, and my erstwhile employer the King's Fund.

Proponents of radical change tend to exaggerate the defects of the status quo and romanticize the alternatives and Spiers is guilty of this. For example, he claims that taxation-funding has created wide inequalities in access to care in the British NHS whereas in the European social insurance systems 'the poorest are treated immeasurably better', yet no evidence is supplied to support this assertion. In discussing the merits of European systems he implies that Bismarck social insurance systems empower consumers to a much greater extent than systems which rely on taxation-funding, although again there is little evidence of this.³ He fails to discuss other health systems—for example, those in Spain and Sweden—in which reliance on taxation-funding has led to reasonably equitable provision of a high standard of healthcare.

In Spiers' brave new world the poor would be guaranteed 'pretty good care'. However, what he has in mind is guaranteed access to the basic package only, with additional services purchased out of pocket or through top-up insurance. The rich would still be able to purchase more and better quality services than the poor. He offers the current organization of optical care in Britain as an example of how a voucher system would work. People in receipt of income support, children, pensioners and people with special health difficulties or complex prescriptions are entitled to NHS vouchers to be spent in privately managed opticians' shops. Rich and poor purchase their sight tests and glasses in the same marketplace and consumers are free

to purchase additional, non-essential services if they can afford to pay. This sounds quite reasonable—few would argue that public funds should be used to subsidise the cost of expensive fashion frames—except that in practice NHS contributions no longer cover the full cost of sight tests and opticians are having to cover the difference by increasing charges for glasses and contact lenses.⁴ A report from the National Consumer Council found that some older people are now deterred from having sight tests because they are concerned about the cost of glasses.⁵ Erosion in the value of the voucher is an ever-present risk and in a privatized system this inevitably impacts more on the poor and disadvantaged.

Spiers is scathing about attempts to ration services based on normative criteria or professional needs assessments. Yet this would be an inevitable feature of his proposed system because the core package or minimum standard of care would have to be defined if the Government, or an independent regulator, was to guarantee universal access to 'pretty good care' with funding from the taxpayer underwriting this. Reference to 'needs' and 'norms' would be unavoidable if the system was to be seen as fair and patients would need some form of protection from market failure.

Where Spiers does hit the mark is in pointing to the limitations of the Government's current efforts to promote patient involvement and choice. Increases in lay involvement on committees and provision of limited choice of treatment location to those undergoing elective surgery, while welcome initiatives in themselves, will not achieve the fundamental changes that are needed to tackle the dependency culture that a paternalistic system has created. I agree with many of his *goals*—guaranteed prompt access to a core package of quality care for all; encouragement of personal responsibility; incentives to take account of patients' preferences; a system which empowers individuals—but I don't agree with his proposed *means*.

The NHS has suffered from too much structural change, most of which has made little difference to patients. We do need to focus effort on changing the balance of power between those who use health services and those who provide them, but a voucher system is not the answer. The scenario described by Spiers seems most unlikely to come about in the foreseeable future unless the current direction of travel turns out to be a catastrophic failure. As Spiers himself admits, there is no groundswell of public opinion calling for a change in the funding system, least of all for an increase in direct payments by patients. It would be a brave political party that put abolition of the NHS at the top of its agenda during an election campaign. Meanwhile, more funds *are* being found for the NHS from public resources, serious effort *is* under way to increase capacity and quality, and patient empowerment and choice are higher up the policy agenda than they ever have been. The current reforms must be given a chance to work before we start planning the overthrow of the entire system.

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Foundations of Evidence-Based Medicine

Milos Jenicek

392 pp Price £59.99 ISBN 1-84214-193-7

London: Parthenon Publishing, 2003

‘As soon as he got home, he went to the larder; and he stood on a chair, and took down a very large jar of honey. It had HUNNY written on it, but, to make sure, he took off the paper cover and looked at it, and it looked just like honey. “But you never can tell”, said Pooh. So he put his tongue in it and took a large lick. “Yes” he said, “it is. No doubt about that. And honey I should say, right down to the bottom of the jar. Unless, of course,” he said, “someone put cheese in at the bottom just for a joke. Perhaps I had better go a little further just in case. . . . Ah!” And he gave a deep sigh. “I was right, it is honey, right the way down.”’

A A Milne,
Winnie-the-Pooh (1926)

The prior probability of Pooh’s jar containing only honey would have been so strengthened by the likelihood ratio of the appearance of the jar’s contents, its smell, its label, its position in his larder and the lack of availability of cheese, that a sensible bear would have accepted without thought a posterior probability approaching unity as being good enough without having to eat the contents of the whole wretched jar. And surely a sensible bear would not have eaten any of its contents if he had known that this high carbohydrate consuming behaviour would increase his relative risk of diabetes and ursine coronary heart disease by a factor of three. But, as with patients so with bears, there are other elements that cannot always be factored in; for example, in this case the certain truth that bears like honey. Therein lies the difficulty with evidence-based medicine (EBM); how do we translate studies done on large amorphous populations to individuals? The need is urgent, since UK National Service Frameworks (NSF) increasingly insist on patients receiving drugs from which over 95% will not benefit; and in the future an element of general practitioners’ remuneration will be based on prescription of preventive drugs of no benefit to the majority of patients who receive them. Some feel that the numerical illiteracy of doctors is being exploited by drug companies and by authors of NSF and NICE guidelines as well as by editors of mainstream journals who talk up relative risk reduction figures to hit the headlines but omit to tell us about the absolute risk reduction. Interpretation of new laboratory tests such as serum atrial natriuretic peptide and d-dimer crucially require an understanding of sensitivity and

prior probabilities to make any sense of their meaning. Few doctors feel easy with numerical expressions of uncertainty, but we must come to terms with these if we are to adequately inform our patients.

Does Jenicek’s *Foundations of Evidence-Based Medicine* help fill our knowledge gap? The author’s aim is to write for the uninitiated, the curious and the doubtful and, since I identified with such people, I was looking forward to reading it. But with these lofty aspirations ringing in my ears I felt let down as I reached its end. The style of writing is the main problem. The book purports to make the message short and sweet but it rambles. The text is expansive with lists of adjectives and dependant clauses dragging one down and there are grammatical errors that interfere with the meaning. There are numbered headings, subheadings and sub-sub headings, sometimes in bold font, sometimes in italics, and then there are subheading bullet points, sections in bold text and many brackets. It’s too much. There are difficult mathematical equations made more difficult by lack of explanation of the meaning of abbreviations and throughout the book there are graphs with titles missing from their axes. The author’s flights of ideas sometimes sparkle but at other times leave one quite dizzy. In the middle of a discussion analysing our decision on whether to treat a streptococcal sore throat we move suddenly to the value of gastrin measurement in Zollinger–Ellison syndrome.

I blame the publishers. The facts are all here and much original thought, but the high noise to signal ratio makes it difficult to find what one is looking for. I still don’t know when I should use odds ratio and when relative risk reduction, when sensitivity and when positive predictive value, and when I looked up the latter terms in the index, to have a second go, I found they weren’t there even though they are dealt with in the text. Bayes’ theorem, one of the cornerstones of EBM, is also missing from the index although present in the text. There are good points, though. Each chapter is extensively referenced and there are some quotable quotes and there is a good section on chaos theory. Perhaps if a second edition were to be considered it could be honed down considerably, with more of a cutting edge and more practical examples. Until then I think David Sackett’s *Evidence Based Medicine* at a fraction of the price is the preferred buy—or, better still for novice or expert, read the relevant chapters in Gird Gigerenzer’s *Reckoning With Risk* whose use of natural frequencies certainly illuminated EBM for me; alternatively there are internet sources such as www.nettingtheevidence.org.uk or Bandolier.

I fear if Pooh read this book he would still have no honey left over for the heffalump trap and worse no honey for his midnight feast. But maybe he knew all along the very small effect that reducing his honey consumption would have on his absolute risk of ursine heart disease and judged

this to be more than offset by the state of sublime happiness he enjoyed while eating honey; this latter state of grace being prosaically dismissed by aficionados of EBM as a 'utility'.

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Survival Skills for Doctors and their Families

Ruth Chambers, Kay Mohanna, Steph Chambers
152 pp Price £21.95 ISBN 1-85775-990-7 (p/b)
Abingdon: Radcliffe Medical Press, 2003

'You have to be careful—not to bring up topics that you know will upset him—and try to keep out of his way a bit. It's hard to keep my little sisters quiet and I always get the blame if they fight.'

These are the words of a doctor's child, and they ring true to me as the eldest of four in a family where both parents were doctors. Despite this start in life I took up medicine and married a doctor.

I welcome this book, at a time when doctor-stress is increasingly evident. A chapter on 'career-marriage conflict' has many echoes of my own life and offers striking insights into the power play between the partners as they work out their career paths. With seven patterns to choose from, most medical marriages are recognized and explained.

As yet I have not faced serious family illness but I value the comments and observations made in Chapter 8. Boundaries can be blurred and non-medical members of the family may put pressure on us, the doctors. The best policy is to let non-related medics take charge, but this excellent advice is at times very difficult to follow. The story of the general practitioner who felt that she had to catheterize her own father is particularly distressing.

My pleasure in and respect for this book were only diminished by the attempts to construct a management plan. Neither of the two medical families to which I belong would find the time, the inclination or the necessary introspection to use the structure offered. However, all families are different and for some it will offer a solution or a path to a solution. Doctors have never been good at recognizing the needs of our families or ourselves. I am grateful to Professor Chambers, Dr Mohanna and their families for the insightful book they have given us, and recommend it to all doctors.

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Caring for the Dying at Home

Keri Thomas
365pp Price £27.95 ISBN 1-85775-946-X (p/b)
Abingdon: Radcliffe Medical Press, 2003

Most people, when asked where they would wish to die, will say in their own home, supported by family and healthcare professionals known to them. At present, many instead die in hospital, and in *Caring for the Dying at Home* Keri Thomas shows how existing structures can be strengthened to allow more people to achieve their wish for a home death.

Written in the main by a general practitioner, the book deals with three related areas in some depth. The middle section has contributions from a palliative care consultant and deals with key features of palliative care for patients with common cancers. This section is perhaps the weakest, not providing sufficient detail to answer practical questions that arise day-to-day in the care of the dying.

The first part entitled 'Palliative care at home: why is it important?' explores the changing face of medicine and attitudes to death and dying. An overview of the palliative care movement and ways of integrating care of the dying involving specialist care in the context of the primary healthcare team provides the setting for the main thrust of the book, which is a description of the Macmillan Gold Standards Framework (GSF). This is a phased programme designed to raise the standard of end-of-life care in the community. Too often end-of-life care has been delivered in an uncoordinated fashion and not based on best evidence. This is not surprising considering the rising workload in primary care, the effect of an ageing population, the lack of resources at community level and the professional isolation experienced by many general practitioners. The GSF seeks to address problems of lack of coordination, poor communication and professional isolation by taking a primary care team through a stepwise process over a period of 6–12 months.

The steps are referred to as the seven Cs—namely, communication; coordination; control of symptoms; continuity; continued learning; carer support; and care of the dying (terminal phase). Rather than just deliver yet another set of guidelines to an already beleaguered primary care profession, Macmillan have actually tested the GSF initiative and Keri Thomas is involved in qualitative and quantitative evaluation of the scheme. Practices registering for the GSF programme receive practical support from a local Macmillan facilitator, a toolkit, conferences relevant to the programme and the offer of evaluation of the practice's progress.

Keri Thomas writes with conviction, her own life being touched by personal tragedy. The book is laced with

quotations from participating health professionals and patients that help break up the text and bring alive the issues under debate. At times one feels that lecture notes are being too closely followed (with references to Maslow, needs/support matrices and Venn diagrams), but the section on bereavement and accompanying sources of help and words of wisdom I found moving and helpful for my future practice.

So who needs to read/refer to this book? I think a practice team conscious of the need to improve and maintain end-of-life care, particularly with the destabilizing effect of opting out of 24-hour responsibility under the new GP contract, will do well to study the Gold Standard Framework. Primary care organizations (possibly through their cancer-lead) ought to consider the Macmillan GSF, particularly in the likely event of practices ceasing their 24-hour commitment. An adequately resourced initiative led by a primary care trust could confidently expect to improve care for those dying at home. Finally, the primary health-care professional wishing to develop an interest in end-of-life care would find the chapter on Evidence-based Care, with some ninety useful references, a good starting-point.

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The Breast Cancer Wars: Fear, Hope and the Pursuit of a Cure in Twentieth Century America

Barron H Lerner

408pp Price £11.99 ISBN 0-19-516106-8 (p/b)

Oxford: Oxford University Press, 2003

The paperback edition of Barron Lerner's gripping medical and cultural history of breast cancer in twentieth-century America, first published in 2001, contains a postscript about the latest 'breast cancer war'. As historian, clinician, scientist, he saw that the same themes were being played out in the near pandemonium that ensued from a front-page story in the *New York Times*. This new skirmish between screening sceptics and believers revolved around the findings of a systematic review by Olsen and Götzsche (*Lancet*, 2001; 358: 1340–2) showing that there was no evidence that mammographic screening reduced mortality from breast cancer and that it led to more aggressive treatments. For Lerner the episode was a further demonstration of how social and cultural factors can influence the interpretation of scientific data. Evidence is still an ineffective weapon against belief.

The Breast Cancer Wars teaches us that disease cannot be understood outside its social and cultural context: culture, philosophy and attitude determine the acceptability of a

course of action. In this exciting and wide-ranging narrative, Lerner opens our eyes to appreciate that evaluation of diagnostic and therapeutic interventions has always depended on time and place. The personal accomplishments of colourful and influential characters from Sir William Halsted onwards are placed in their proper historical context, set against the larger social system in which they worked. Although mortality statistics remained unchanged, belief in Halsted's radical mastectomy kept it going for three-quarters of a century. Mid-century challenges by proponents of biological predeterminism, who using new statistical approaches proposed that the inherent biology of individual breast cancers—as opposed to early intervention—most influenced whether patients lived or died, were vigorously resisted by surgeons. Rose Kushner, American journalist and breast cancer patient, posed a conspicuous challenge to the traditional authoritarian physician/patient relationship, radical surgery and the one-step procedure, in a vigorous, intelligent and well-researched campaign. In *Breast Cancer: a Personal and Investigative Report* (Harcourt Brace Jovanovitch, 1975) she questioned surgeons' blind adherence to Halsted's methods. Kushner's main target, as a civil libertarian, was the arrogant way the medical profession went about its business. The language of the rallying call to women to 'have a finger in their own destiny' and engage as powerful combatants in this new-style battle was irresistible. Activism was born.

Armed with the insight that Lerner's riveting history can provide, clinicians, patients, medical journalists, the media, politicians, policy-makers and scientists could learn to reduce the bloodshed and collateral damage inflicted on women by over-zealous detection and eradication. Today, as in Halsted's time, so much of what we do and what we believe hinges on the perennial disagreement over the value of early detection. The latest skirmish again demonstrates the limits of scientific evidence to resolve contentious clinical issues. A soldier fears maiming more than death: saved lives must not be at the expense of damaged lives.

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An Atlas of Hair Pathology—with Clinical Correlations

Leonard C Sperling

158 pp Price £66.99 ISBN 1-84214-203-8 (h/b)

London: Parthenon, 2003

Leon Sperling has long been known for his hair pathology expertise and his *Atlas of Hair Pathology* also reveals his skills as a clinician. The visual components cross in a well-balanced way between disease morphology and pathology.

Normal follicular anatomy is covered in detail, in particular the technical processing needed to produce the sections for horizontal viewing: this methodology is of great value for the histopathology of chronic telogen effluvium and androgenetic alopecia. In 28 chapters Sperling deals with all the areas of hair and scalp diseases, including detailed attention to differential diagnosis—particularly well covered in the fibrosing alopecias. The sections on senile alopecia (senescent balding) are very important; many clinicians and skin pathologists in their ignorance doubt the existence of this entity—but it does exist, as shown here with great clarity. I cannot imagine any dermatopathologist not wanting to possess this atlas.

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Ethics Consultation: from Theory to Practice

Mark M Aulisio, Robert M Arnold, Stewart J Younger

214 pp Price £33.50 ISBN 0-8018-7165-4 (h/b)

Baltimore: Johns Hopkins University Press, 2003

In the UK it would now be considered extraordinary to conduct research without consulting a research ethics committee. Yet clinical ethics consultation—arrangements for seeking advice about difficult questions of values in clinical practice—is almost unknown in this country. Despite the longstanding custom of consulting expert colleagues on difficult clinical issues, the idea seems strange to many. This is not so in the United States, where clinical ethics consultation services are well established. The conduct of such services is the subject of this book. The need for ethics consultation is taken as axiomatic, and the book covers a wide range of issues about the role and conduct of these services.

What is the purpose of ethics consultation? Is it to clarify the issues in a particular case (a traditional role for moral philosophers), to facilitate decision-making for those involved, to help them communicate and resolve problems in personal relationships, or to offer an 'expert opinion'? If the last, is this merely a matter of technical skill, or must practitioners also have a particular moral education and quality of moral character? Should ethics consultation be offered by individuals or by a committee? Should there be a formal system of certification for ethics consultants, as with other specialists? From what perspective does one offer ethical advice in a culturally and morally pluralistic society? How should such services be organized, and what support do they require? The United States is a very different culture from our own, but there are issues here for the UK. The rational analysis of ethical problems is as much an intellectual skill as clinical diagnosis, and training in this skill now forms part of the undergraduate curriculum of most

UK medical schools. It does not seem unreasonable therefore that, faced with a particularly tricky ethical problem, a doctor should seek the advice of someone who has paid particular attention to learning this skill, any more than it is odd that I, as a general practitioner, should ask a cardiologist for help with a particularly recalcitrant case of hypertension.

When faced with a tricky ethical problem, as with a clinical dilemma, most doctors will naturally discuss it with colleagues, but arrangements for doing this in the UK tend to be informal and unstructured. Might more formal structures lead to better decisions? Clinical work places tremendous psychological pressure on practitioners, and our culture does not always provide satisfactory mechanisms for dealing with these. Dinniss (*BMJ* 1999; **319**: 929) has discussed the phenomenon whereby, when doctors meet at the dinner table, they are soon exchanging horrific stories about their medical experiences—a sort of catharsis, he judges, to cope with the emotional and psychological pressures. Among these, along with death and suffering, are conflicts of values, where a decision has to be made and all the options are wrong. The idea that doctors are omniscient, invulnerable superbeings is no longer dominant in our society. Yet paradoxically expectations of a perfect standard of service have risen, fuelled by political pressures, league tables and organizations promoting patients' rights. In this climate a more formal system for seeking help with difficult ethical problems might not only protect patients but also support doctors.

In their book, Aulisio and his co-authors offer a good insight into how such systems work in practice. For the UK culture and healthcare system they would have to be very different, but the observations recorded here deserve close study by anyone who contemplates setting up a referral system for medical staff facing ethical dilemmas.

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Forensic Medicine: Clinical and Pathological Aspects

Editors: Jason Payne-James, William Smock, Anthony Busuttill

832 pp Price £135 ISBN 1-84110-026 (h/b)

London: Greenwich Medical Media, 2002

There is much overlap between the activities of forensic physicians and pathologists, and legal-medical work can demand the interaction of a plethora of different specialists. With this in mind, the editors have brought together 76 acknowledged specialists to create a heavyweight forensic publication. Its main aim is to be a source of information for all practitioners.

The book is divided into four main sections—General Issues, Causes and Investigation of Death and Injury, Practical Investigations, and Management and Related Specialties. The pages are easy on the eye, with clear images and diagrams interspersed gently within the text. Each chapter ends with a plentiful list of references. The first section begins with general concepts and nomenclature, with a smattering of historical perspectives, taking a brief tour of the development of legal systems. The coronial system and medical examiner systems are also discussed in some depth. A separate chapter is dedicated to Shari'ah law, the reason being that one-fifth of the world's population is Muslim. This was an enlightening chapter for myself a non-Muslim. An expansion upon how Shari'ah law nestles within a multicultural society would have made the chapter still more informative, although perhaps going beyond the design of the book. Scene investigation is also discussed in a short chapter, with more specific scene management dealt with in other chapters.

The second section comprises a traditional classification of the circumstances in which one becomes deceased. The to-be-expected (and essential) chapters include gunshot trauma, falls from height, drowning and diving deaths. Although some of the forensic techniques are not used in day-to-day work, the short chapter on the pathophysiology of wound healing touches upon the modern developments in dating wounds. This is a step in the right direction, for forensic textbooks traditionally have not been forward-looking. Pearls of wisdom exude from the chapter by Stephen Cordner (Victorian Institute) on ways to distinguish suicide, accident, murder and natural death from each other. My only criticism is that it is not long enough; indeed, the content deserves a stand-alone book. Any forensic practitioner can deal with the straightforward case, but the difficult case requires not just fact but also skilled interpretation and experience. One omission I did note in the section concerning head injury was discussion of the utility of beta amyloid precursor protein and cluster

designation number 68 in head injury. This will need to be addressed in future editions of the textbook. I also note a *faux pas* in this chapter—a stab injury causing a laceration. Well in a big book like this, *c'est la vie*.

Section three starts with a fascinating un-put-downable chapter, as R J Levin dips into the physiology of male and female sexuality. This is most relevant to the police surgeon, especially in explaining to a victim of rape why his or her body responded in the way it did. This chapter gives answers to vital questions such as to why a male victim of rape (by another male) may get an erection. Also noteworthy is the presence of a chapter dedicated to elder abuse. This difficult subject is dealt with well. A transportation-medicine chapter focuses upon the road traffic accident, and is impressively illustrated. Only a short section deals with air traffic accidents, although one could consider this as part of the mass disaster chapter. Fitness to be interviewed is examined in depth, with an expansive discussion concerning the problem of false confession.

The final section deals with the related specialties, including anthropology, haematogenetics, odontology, psychology, psychiatry, imaging, entomology and statistics. These chapters are précis of much larger subjects. They do, however, introduce one to unfamiliar techniques such as cheiloscopy and rugoscopy. The imaging chapter is particularly useful, detailing techniques and guiding the reader.

This is a thorough book, touching upon and delving deeply into most of the subjects encountered by those who engage in medicolegal work. It is a perfect reference for those practitioners who deal with both the living and the dead. I also recommend it to those sitting exams, particularly those set by the Society of Apothecaries, London.

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